# Table of Contents

## 1 WYHealth... Get Plugged In! ...........................................5
  - Health and Wellness ..................................................5
  - WYHealth...Get Plugged In Website ..................................6
  - Healthy Habits Weight Management Program ..........................6
  - Case Management ................................................................7
  - Behavioral Health Case Management ....................................8
  - Wrap Around Model .......................................................9
  - Appropriate Care Site Program (Emergency Room) ..................10
  - Pharmacy Lock in Program .............................................10
  - Wyoming Department of Health Oral Health Programs ............10
    - Preventive Pediatric Care ..............................................11
    - Severe Crippling Malocclusion Program ............................11
    - Contact numbers for Oral Health programs: .......................11
  - WY Medicaid Waiver Programs ........................................11
  - Breast and Cervical Cancer .............................................12
  - Pay for Participation (P4P) .............................................12
  - Disability Determinations ..............................................13
  - Pre-Admission Screening and Resident Review (PASRR) ............13
  - Total Health Record ....................................................13
    - THR for Medicaid Providers ........................................13
    - THR for Patients ....................................................14
  - Transportation ............................................................14
  - Xerox Networking Activities ...........................................15
    - Providers ..............................................................15
    - Patients ...............................................................15
    - Community ............................................................15
  - Satisfaction Surveys ....................................................15
  - Grievance and Complaint Process .....................................15

## 2 Utilization Management .................................................17
  - Prior Authorization .....................................................17
    - Submission of Information for the Prior Authorization ............18
    - Criteria for Review ....................................................18
    - Approval of Prior Authorization (PA) ..............................18
    - Denial of Prior Authorization ........................................18
    - Appeal Process .......................................................19
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Obtain a Timely Prior Authorization</td>
<td>19</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>20</td>
</tr>
<tr>
<td>Continued Stay Reviews</td>
<td>20</td>
</tr>
<tr>
<td>Case Management Services</td>
<td>20</td>
</tr>
<tr>
<td>Failure to Obtain Timely Admission Authorization</td>
<td>20</td>
</tr>
<tr>
<td>Retroactive Eligibility</td>
<td>20</td>
</tr>
<tr>
<td>Admission Authorization Notification</td>
<td>20</td>
</tr>
<tr>
<td>Continued Stay Reviews</td>
<td>21</td>
</tr>
<tr>
<td>Submitting a CSR</td>
<td>21</td>
</tr>
<tr>
<td>CSR Determination</td>
<td>21</td>
</tr>
<tr>
<td>Extraordinary Care</td>
<td>22</td>
</tr>
<tr>
<td>Retrospective Reviews</td>
<td>22</td>
</tr>
<tr>
<td>Procedure for Obtaining a Retrospective Review</td>
<td>22</td>
</tr>
<tr>
<td>Utilization Timeline Requirements</td>
<td>23</td>
</tr>
<tr>
<td>Random Post Pay Reviews</td>
<td>23</td>
</tr>
<tr>
<td>Focused Reviews</td>
<td>24</td>
</tr>
<tr>
<td>Mortality Reviews</td>
<td>24</td>
</tr>
</tbody>
</table>

3 Psychiatric Residential Treatment Facility                        25

4 Inpatient Census Report (ICR)                                      34

5 Utilization Management Forms Appendix A                             35

6 Referral Forms Appendix B                                           71

7 Utilization Management Criteria Appendix C                          74

Wyoming Nursing Facility Extraordinary Care Criteria                  75
Introduction

This provider manual offers you information and processes to assist you in working with WY Medicaid patients. This manual also will introduce you to Xerox Care & Quality Solutions, Inc. and the programs and service they provide to WY Medicaid recipients.

In July 2012, Xerox Care & Quality Solutions, (Xerox) was selected by the Wyoming Department of Health, Office of Healthcare Financing to provide health management service to WY Medicaid clients. Xerox developed a comprehensive health management program that is innovative and continuing to evolve to meet the ever changing health care needs in Wyoming. The program is called WY Health... Get Plugged In and offers utilization management, disease management, case management and health and wellness. Each program is discussed in detail in this manual.

For more information about Xerox WY Health…Get Plugged In program and all of the forms and utilization management criteria visit our website at http://www.wyhealth.net.
1 \(\text{WY Health... Get Plugged In!}\)

The \textit{WY Health... Get Plugged In} program is available to all WY Medicaid clients to assist with their healthcare needs. The program is a free benefit that is offered to all Medicaid clients who may utilize any of the programs or services provided in the program. Xerox offers a variety of ways to identify clients appropriately for engagement into the program. Clients are identified through medical and pharmacy claims data, providers, hospitals, and other facilities/programs. In addition, clients or families may self-engage into the program by calling the dedicated phone number toll free at 1-888-545-1710. Providers may refer any of their patients to the program by calling 1-888-545-1710 or by faxing a Xerox Referral Form to 1-888-245-1928 (See Appendix B).

Xerox provides a 24 hour / 7 day a week toll free provider/nurse line to provide information about places recipients may receive healthcare services after provider office hours and when to access the Emergency Room (ER). In addition, the nurse can provide Wyoming county specific education and resource information. The 24/7 nurse line number is 1-888-545-1710.

Xerox offers WY Medicaid clients experienced licensed healthcare staff to work with them individually or in group settings. The staff consists of licensed Registered Nurses (RN), Licensed Clinical Social Workers (LCSW), Licensed Professional Counselors (LPC), a clinical psychologist and a medical doctor. The licensed staff is referred to as health coaches in the \textit{WY Health... Get Plugged In} program. The health coaches work with the clients telephonically and in some cases face to face. They are available to coach clients in making good healthcare choices for themselves and/or their families. Health coaches provide the following:

- Education
- Resources
- Support
- Information about age appropriate health screenings
- When to access the Emergency Room

\textbf{Health and Wellness}

Xerox encourages preventive care and educates clients about health and wellness topics to promote healthy living. The \textit{WY Health... Get Plugged In} program provides a health and wellness program called Healthy Habits. The program has a 12 month calendar with monthly health topics that encourages health screenings and testing. The calendar is available at the WY Health website at \url{http://www.wyhealth.net}. The health and wellness program features:

- Education about health topics
- Encouragement to practice habits that support ongoing health
- Support and coaching to be effective in self-management of health
The dedicated WY Health Get Plugged In website can be found at www.wyhealth.net. This site offers an avenue by which providers can find all the information they need related to making referrals for care management, prior authorization forms, admission criteria, and informational material. This SSL-encrypted site is also available in a mobile version that is accessible by all commonly used operating systems, such as those used by iPhones, Android, BlackBerry, and Windows-based smartphones.

Navigation on the WY Health website is user-friendly and its dedicated pages allow the user to access information that is relevant to their needs. Below is a list of the commonly used tabs along with their respective links.

<table>
<thead>
<tr>
<th>Tab</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Wellness</td>
<td><a href="http://www.wyhealth.net/Health_and_Wellness.html">http://www.wyhealth.net/Health_and_Wellness.html</a></td>
</tr>
<tr>
<td>Healthy Habits</td>
<td><a href="http://www.wyhealth.net/Healthy_Habits.html">http://www.wyhealth.net/Healthy_Habits.html</a></td>
</tr>
<tr>
<td>24/7 NurseLine</td>
<td><a href="http://www.wyhealth.net/24_7_NurseLine.html">http://www.wyhealth.net/24_7_NurseLine.html</a></td>
</tr>
<tr>
<td>Behavioral Provider</td>
<td><a href="http://www.wyhealth.net/Behavioral_Provider.html">http://www.wyhealth.net/Behavioral_Provider.html</a></td>
</tr>
<tr>
<td>PASRR</td>
<td><a href="http://www.wyhealth.net/PASRR.html">http://www.wyhealth.net/PASRR.html</a></td>
</tr>
<tr>
<td>Initiatives</td>
<td><a href="http://www.wyhealth.net/Initiative_Information.html">http://www.wyhealth.net/Initiative_Information.html</a></td>
</tr>
<tr>
<td>Provider Resources</td>
<td><a href="http://www.wyhealth.net/Provider_Resources.html">http://www.wyhealth.net/Provider_Resources.html</a></td>
</tr>
<tr>
<td>Forms and Brochures</td>
<td><a href="http://www.wyhealth.net/Forms.html">http://www.wyhealth.net/Forms.html</a></td>
</tr>
</tbody>
</table>

In addition to the links above, each month a health topic is featured and helpful information is provided along with links to additional resources.

**Healthy Habits Weight Management Program**

Xerox has adapted successful weight management components and developed them into a comprehensive interactive model for WY Medicaid clients. The program incorporates a blended model with medical and behavioral health clinicians providing education, support calls, and weekly telephonic group sessions. The goal of the program is to provide clients with knowledge, skills, and tools to help clients make lifestyle changes and adopt long-term habits to maintain weight and/or weight loss.

Xerox’s Healthy Habits weight management program requires close communication and collaboration with physicians and support through community resources with the goal of improving the quality of life and promoting lifelong skills and strategies to encourage weight loss and/or prevent the progression of further weight gain. In addition, the WY Health…Get Plugged In Healthy Habits program objectives aid in reducing complications associated with co-morbid conditions related to obesity. The program provides clients with simple self-management techniques and strategies to improve eating habits, increase quality of life and improve overall health. The program is aimed at introducing 12 life-long Healthy Habits presented by medical and behavioral health clinicians that provide techniques and support to incorporate the habits in their
The Healthy Habits are designed to help clients identify their current eating habits and provide tips on choosing healthy foods in appropriate portions, increasing activity, and evaluating progress. The Healthy Habits are incorporated into the weekly group discussions and specific goals are encouraged to help clients make small changes that overtime will become Healthy Habits. Providers can refer any client into the Healthy Habits weight management program by calling 1-888-545-1710 or by faxing a referral form to 1-888-245-1928 (See Appendix B).

Case Management

Case management provides proactive, medically appropriate, cost effective, coordinated care to clients with complex medical conditions, or for whom a critical event has precipitated a need for care coordination and healthcare support. The management of cases is achieved through a collaborative process in which a clinician assesses, plans, facilitates, and advocates for options and services to meet an individual client’s health needs through communication and available resources to promote quality cost-effective outcomes. Xerox views case management as a critical component of the overall “care management” program inclusive of both behavioral and medical conditions. As such, the Xerox program is broader in scope than traditional case management programs that focus only on the highest risk clients. The goal of the program is to assist clients requiring care coordination as well as clients with multiple or complex conditions; helping them navigate the healthcare system; and adopting strength based self-management practices.

Xerox incorporates three tiers of case management with Tier 1 being low level case management and Tier 3 being intensive case management. The following outlines examples of cases appropriate for case management as well as what is provided in the three different case management tiers.

### Identification
- ER Frequent User
- Readmission Risk
- CyberFormance
- Predictive Modeling
- Plan Referral
- Provider Referral
- 24/7 Nurseline

### Engagement
- Contact
- Dialogue
- Social Media
- Interactive Strength-based Assessment
- Client Driven Goals and Plan

### Community
- Individual Client
- Family
- Providers
- Wellness & Recovery Support Team
- Peer Support
- Social Network
- Support Groups
- Agencies
- Interests and Hobbies
- Volunteers

### Evaluation of Successes
- Client Defined Milestones
- Plan for Setbacks as learning tools
- Team Feedback
- Client/Family Experience of Empowerment
- Client/Family Experience of Satisfaction and Success
- Resource Tracking for Utilization and Cost
Clients are referred to case management in several ways: providers, facilities, self-referral, family referral, etc. In addition, clients are identified for case management from claims data, pharmacy claims data, or other specific reports that identify clients who are at high risk for admission and/or re-admissions.

To make a verbal referral to Xerox case management you may call 1-888-545-1710 or you may fax a Xerox Referral Form to 1-888-245-1928. (See Appendix B)

**Behavioral Health Case Management**

Xerox is partnered with WY Medicaid to provide a comprehensive behavioral health program. The Xerox blended utilization management and care management team consists of Licensed Clinical Social Workers, Registered Nurses, and Licensed Professional Counselors. Xerox understands the importance of ensuring Wyoming youth and adults receive appropriate behavioral health services in acute, Psychiatric Residential Treatment Facility (PRTF), and outpatient settings.

Xerox care managers begin to work with facilities, families/guardians, providers, and community services at admission to acute or PRTF level of care. Care managers assess client’s symptomatology and treatment for medical necessity, as well as start the discharge planning process when a client is first admitted, to ensure a plan is in place for the client to be successful in the community. Additionally, care managers closely monitor a client’s clinical progress and make best practice recommendations throughout the client’s inpatient stay to address length of stay and treatment concerns.

Xerox care managers are also available to all behavioral health outpatient clients as well. Care managers can assist complex behavior health clients and those with comorbidities to get coordinated care and access resources that will help them to be successful in the community. Care managers also provide support and education to clients and parents/guardians of clients.

To make a verbal referral to Xerox behavioral case management you may call 1-888-545-1710 or you may fax a Xerox Referral Form to 1-888-245-1928. (See Appendix B)

Xerox has fostered a strong relationship with Seattle Children’s Hospital (SCH). Through contracts that WY Department of Health has developed with SCH, Xerox is able to access child and adolescent psychiatrists to provide specialized evaluations where limited community resources
exist. In addition, Care managers recommend and facilitate second opinion evaluations with SCH clinicians for children who are in PRTF and not making progress. The telephone number to contact SCH is 1-877-501-7257.

Additionally, the Department of Health has contracted with SCH to offer free child psychiatry consultation services to all primary care providers throughout Wyoming. The Partnership Access Line (PAL) can be reached at 877-501-7257. Providers can use PAL to consult for any patient that is under 21 or is an adult diagnosed with a significant developmental disability. You can learn more about PAL at www.wyomingpal.org.

Wrap Around Model

Xerox incorporates the wrap around model in our medical and behavioral health case management programs. Wraparound is a philosophy to engage individuals and families on achieving their goals. It provides the stepping stones to allow the individual and families to identify their needs and advocate for the services that will meet those needs. Wraparound follows ten principles and they are:

1. **Individual/Family Voice and Choice** - Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. **Individualized** - To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

3. **Strength-based** - The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

4. **Community Based** - The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

5. **Natural Supports** - The team actively seeks out and encourages the full participation of team members drawn from family members’ networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

6. **Team Based** - The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

7. **Culturally Competent** - The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.

8. **Collaboration & Integration** - Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members’ perspectives, mandates, and resources. The plan guides wraparound.

9. **Persistent Unconditional Care** - A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in
the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

10. **Outcome Based & Cost Responsible** - The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

## Appropriate Care Site Program (Emergency Room)

It has been shown through analyzed data that a potential three (3) million dollars in costs could be achieved by better managing the care seeking behaviors of frequent ER utilizers. It is believed that outreach and working with clients who use the ER for non-emergent treatment/services can help reduce the high medical costs associated with non-emergent costs.

Xerox and WY Medicaid are launching an ER diversion pilot called the Appropriate Care Site Pilot Program. The design of this pilot is to develop evidence based approaches to work closely with clients who over utilize the ER for non-emergent care. Our partnership with the Wyoming Department of Health and medical homes in the area has produced several interventions for the ER pilot program. The use of the daily ER Medicaid client list and the Total Health Record (THR), are tools that are available to assist Xerox in identifying clients who use the ER for non-emergent care. Xerox contacts clients to identify reasons for using ER services. In addition, Xerox uses the THR to examine utilization histories of Medicaid clients who used ER services. The Appropriate Care Site Pilot program includes a 24/7 Nurse Advice Line, which provides clients the opportunity to talk with a registered nurse before using the ER. The goal with this pilot is to educate clients about preventive care measures and alternative resources thereby avoiding unnecessary medical costs. It is hoped that with further refinement, the pilot will be implemented statewide.

## Pharmacy Lock In Program

The Medicaid Pharmacy Lock-in Program limits certain Medicaid clients to receiving prescription services from a single designated pharmacy provider. Any Medicaid client with claims from multiple prescribers and controlled substance prescriptions from multiple pharmacies within a designated time period is a candidate for this program. Medical histories are reviewed to ensure that clients with certain diagnoses, including cancer, are excluded from the lock-in program. If the client does not meet lock-in criteria, the case is referred to the appropriate program as needed. For questions or concerns about the lock in program, please call the Pharmacy Case Manager at 307-777-8773.

## Wyoming Department of Health Oral Health Programs

WY Medicaid knows how important dental health is to the overall health and well being of a person. Xerox will make reminder phone calls to clients to remind them to attend their dental appointments. The following dental programs are available for WY Medicaid clients.
Preventive Pediatric Care

Preventive dental care as outlined in the EPSDT (Early & Periodic Screening Diagnostic Treatment) which includes an oral examination.

A child should be referred to the dentist as follows:

- When the first tooth erupts and at least every six months thereafter.
- If an oral examination reveals cavities, infection or the child has or is developing a handicapping malocclusion or significant abnormality.
- Topical Fluoride Varnish can be applied by a physician for patients who are at a moderate to high risk for dental caries.

Severe Crippling Malocclusion Program

Orthodontic treatment is available for eligible clients 12-18 years of age. Eligibility is dependent upon financial need as well as medical necessity. The program is designed to help children with severe handicapping conditions which clearly impact function. If a client is currently covered by Medicaid, the dentist may send in a state referral for an orthodontia consultation. If the client is not eligible for Medicaid applications can be obtained from the Public Health Offices.

Contact numbers for Oral Health programs:

- Senior and Marginal Dental Program: Contact Oral Health Services at 307-777-7945 for information.
- Medicaid Dental Provider Services Manager 307-777-8088.
- For Providers, the dental service contact line is 888-863-5806 M-F from 9am to 5 pm.

WY Medicaid Waiver Programs

WY Medicaid provides additional services for clients who qualify for a waiver program. Xerox assists the waiver programs by providing case management or medication reviews as needed. The following are WY Medicaid Waiver programs and contact numbers.

- Acquired Brain Injury Waiver: 307.777.6494
- Adult Developmental Disability Waiver: 307.777.6494
- Assisted Living Facility Waiver: 307.777.7366
- Child Developmental Disability Waiver: 307.777.6494
- Children’s Mental Health Waiver: 307-777-5061
- Long Term Care Waiver: 307.777.7366
Breast and Cervical Cancer

WY Medicaid provides support for women diagnosed with breast cancer, cervical cancer or pre-cervical cancer through the WY Department of Health, Preventative Health and Safety Division, Breast and Cervical Cancer Program. The program provides nurse case managers to review and ensure that they receive appropriate care and continue with their treatment and follow-up. To make a referral to Xerox for case management services, please call 888-545-1710.

Pay for Participation (P4P)

The initial Pay-for-Participation program was launched statewide in 2008. This program was implemented to prevent gaps in care and to improve clinical outcomes with clients with chronic conditions. Providers are reimbursed a higher rate when they complete disease specific or age specific screening, provide health education on chronic diseases and assist with coordination of care. The providers are encouraged to make referrals to Xerox’s WYHealth Get Plugged In program for case management and coordination of services. Xerox provides a team of registered nurses, social workers and licensed professional counselors to assist with the complexity of needs often seen in clients with multiple chronic conditions. Xerox is making efforts to meet with providers and practices to review the P4P program and how the program can benefit them financially as well as to provide them with Xerox’s specialized team to assist their clients with additional support and coordination of care. Please contact Xerox’s Network Coordinator at 1-888-545-1710 extension 3253959 to schedule time to review how to use the P4P billing codes and how the program can benefit your practice.
Disability Determinations

Xerox Care and Quality Solutions, Inc. is contracted by the Wyoming Department of Health to perform medical record reviews and make disability determinations according to Social Security guidelines. The Wyoming Department of Health determines when a disability determination is needed. Referrals, along with medical records, are sent to Xerox. Each medical record review is completed by specially trained physicians and psychologists using medical records from acceptable medical sources.

Pre-Admission Screening and Resident Review (PASRR)

PASRR refers to Pre-admission Screening and Resident Review, a federally mandated program that requires all states to develop a comprehensive process to pre-screen all individuals applying for admission into Medicaid certified nursing facility care regardless of pay source. The purpose of PASRR is to assess, through progressive screening whether applicants for nursing facilities have a serious mental illness (MI) or intellectual disability (MR/ID), and if the nursing facility is an appropriate placement. For those who are currently in a nursing facility, the PASRR is completed on those who have had a change in condition. Information regarding the Wyoming PASRR process is available on the http://www.wyhealth.net website or by calling 1-888-545-1710.

Total Health Record

The Total Health Record (THR) is a web-based record of a patient’s health information generated by compiling information from multiple healthcare encounters. Included in this record are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The goal of the THR is provide centralized and secure online access to a patient’s healthcare information (for patients and their healthcare teams) to promote better patient outcomes and more efficient utilization of services.

THR for Medicaid Providers

The THR offers an online Electronic Health Record (EHR) at no cost to Medicaid providers. This EHR is certified by the Office of the National Coordinator (ONC) and is accessible through a secure Web portal designed for provider use. The EHR provides the following functions:

- E-Chart
- Lab interfaces
- ePrescribing
- Clinical Surveillance
- Clinical Alerts
- Reporting
The EHR also provides functionality to enable providers to meet meaningful use criteria and qualify for EHR incentives, if eligible. The THR system also includes an underlying Medicaid Health Information Exchange (HIE) infrastructure to facilitate transfer of data between EHRs which connect to the Medicaid HIE. Health records for Medicaid patients are exchanged in an electronic format known as a Continuity of Care Document (CCD) using national formatting and secure transmission protocol standards.

**THR for Patients**

The THR also offers an online “user-friendly” Personal Health Record (PHR) at no cost to patients. The PHR allows patients and their providers to view a broad range of the patient’s health information including the patient’s health conditions, treatments, and medication history. Patients also are able to access healthcare professionals and educational materials through the PHR.

The link for the THR is [www.wyomingthr.com](http://www.wyomingthr.com).

**Transportation**

Wyoming Medicaid can assist with transportation to and from medical appointments. Below are some basic travel reimbursement facts and contact information that you can give to your Wyoming Medicaid clients:

- Clients must be eligible on the date of travel.
- Travel reimbursement must be to an actively enrolled Wyoming Medicaid provider.
- Transportation requests can only be made by the client or parent/guardian listed on the case with Department of Family Services.
- Travel requests can be requested for appointments made within the same month or approximately five (5) working days prior to the following month.
- Payments are made within thirty (30) days of receipt of a completed travel packet.
- The Travel Call Center can only accept originals of verification and hotel receipts. If a hotel receipt is not available because you stayed in the hospital or with a friend please include a letter with the information.
- Complete packets must be submitted within one (1) year from date of travel.
- Mileage is calculated by shortest distance from town to town using MapQuest.
- The Travel Call Center is staffed Monday through Friday 9am to 5pm Mountain Standard Time.

The phone number is 1-800-595-0011. Certain travel requests can be made on the Client Secured Web Portal.
Xerox Networking Activities

WY Health Get Plugged In has adopted a model that incorporates community support and collaboration. The community “wraparound” principles guide the outreach activities to build relationships and collaboration between providers, agencies, patients and the communities within Wyoming. (See Wrap Around)

The outreach activities are comprised of three major components:

Providers
- Face-to-face visits to introduce the WY Health…Get Plugged In program and services.
- Supply providers with WY Health printed materials, referral forms, and emails and fax blasts with changes or additions to services.

Patients
- Outreach to Medicaid clients by the Outreach Coordinator has included distribution of WY Health…Get Plugged In program materials, meeting clients at a variety of conference/health fairs and conducting trainings within the communities.
- Program materials are distributed in public places throughout communities.
- Xerox provides a website to Medicaid clients. The website includes information about accessing the 24/7 Nurse Line, the weight management program – 12 Healthy Habits, care management and information to improve overall health and well-being. The website is http: www.wyhealth.net

Community
- Participation in community trainings and meetings that incorporates the Wraparound principles of a team-based approach.
- Outreach has included, and will include, participation in community coalitions, attendance at conferences and the use of local media outlets.
- Attendance at conference and health fairs.

Satisfaction Surveys

WY Medicaid is committed to assuring client and provider satisfaction with coordination of services and services they receive. Annually, a survey is mailed to all providers of WY Medicaid or the providers will receive a telephonic survey by a third party vendor to determine satisfaction with the WY Health…Get Plugged In program. Providers have an opportunity to rate several aspects of the program, as well as provide comments and suggestions. In addition, clients are mailed satisfaction surveys to obtain their input and evaluation of their health coach and services provided to them.
Grievance and Complaint Process

Xerox registers and responds to verbal and written complaints received from clients, client representatives, providers or other interested parties about its utilization management and health management program and services. All comments are important and are viewed as a potential opportunity for improvement. Xerox has three types of complaints that are tracked and followed up on within seventy two (72) hours.

The types of complaints are categorized into the following three (3) types:

- Quality of Care
- Quality of Service
- UM process complaint

If you have a complaint about the WY Health Get Plugged In program, please contact Xerox’s clinical manager by calling 1-888-545-1710 and ask for the clinical manager. Xerox’s clinical manager will review all Quality of Care and Quality of Service complaints within two (2) working days of receiving the complaint. The clinical manager may involve Xerox’s contract administrator or medical doctor if appropriate.

The number and type of complaints are reported to WY Medicaid on a monthly basis.

If the party who issued the grievance/complaint does not feel that the response was satisfactory or was not completed in a timely manner, they may contact Heather Preston the Health and Utilization Management Vendor Manager at 1-307-777-6636, or by email at heather.preston@wyo.gov

Or you can write a letter and mail it to the following address:

Heather Preston  
Wyoming Department of Health  
Division of Healthcare Financing  
6101 Yellowstone Road, Suite 210  
Cheyenne, WY 82002  
Office: 307-777-6636
2 Utilization Management

The goal of Utilization Management (UM) is to reduce inappropriate utilization of services while allowing the individual to obtain the services that best meet his or her healthcare needs. A benefit of Xerox managing both the Health Management (HM) program and UM services is its ability to refer at-risk individuals – those who may benefit from health management, case management, counseling, or other support who are identified within the UM process to its other programs and services.

By reviewing admissions, procedures and services, UM evaluates:

- Medical necessity of an admission, continued stay and/or course of treatment or service ("medical necessity" as defined in Chapter 1, Definitions of the Wyoming Medicaid Rules and Regulations).
- Progress of treatment modalities being provided and assess the need for possible lateral transfer or physician review
- Adequacy of the discharge plan in relation to a client’s capabilities and resources.
- Efficiency of the use of healthcare services, procedures and facilities under the provisions of the Medicaid Rules and Regulations.

Federal regulations require Medicaid programs to review any service (admission or procedure) where it is anticipated or known that the service could either be over or underutilized, or otherwise abused, by providers or clients, or easily result in excessive, uncontrollable Medicaid costs. This is accomplished through prior authorizations for certain procedures and inpatient admissions.

**Are facilities/providers required to complete the Xerox Prior Authorization Form if the client has other insurance?**

The answer is yes. Facilities are required to complete the prior authorization process in instances where the client has other insurance with another carrier or Medicare. If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.

Prior Authorization

Prior authorization (PA) is utilization management that is conducted prior to a Medicaid client’s procedure or admission. Requests for prior authorizations (PAs) are required to be submitted before the initiation of the following services:

- Transplants*
- Weight Loss Surgery
- Vagal Nerve Stimulator (VNS) for Epilepsy
- Inpatient Physical Rehabilitation
- Skilled Nursing Extraordinary Care
- Psychiatric Residential Treatment Facility

*The transplant PAs are effective for one year and will need to be updated if the service is not completed during the first year.
Submission of Information for the Prior Authorization

The provider shall submit a completed prior authorization form and supporting documentation at least three (3) working days before providing services. Xerox may request additional information in order to complete the review. Operational hours for WY Medicaid reviews are 8:00 am to 5:00 pm Mountain Standard Time, Monday through Friday, with the exception of State holidays. Information submitted for UM reviews should be submitted by fax to 1-888-245-1928 or other electronic means. Reviews are not performed over the telephone.

Criteria for Review

Prior authorization (PA) shall be granted if all of the following are met. The service is:

- Covered under WY Medicaid,
- Consistent with the client’s diagnosis, and
- Medically necessary based on established criteria* by the rules of the Division of Healthcare Financing.

*The criteria used to determine medical necessity for all services requiring a PA are available on the internet at the following website: http://www.wyhealth.net.

Granting prior authorization shall constitute approval for the provider to receive Medicaid reimbursement for approved services to be furnished, subject to the requirements of this rule and post-payment review. Prior authorization is not a guarantee of the client’s eligibility or a guarantee of Medicaid payment.

Approval of Prior Authorization (PA)

Once the admission form is received from the facility, Xerox will review the demographics, clinical information and provide a determination to the facility within 72 hours of receipt. If the form is complete and there is supporting documentation for the requested service/admission, the utilization management (UM) reviewer will provide a 10 digit PA number to the facility/provider via letter or other electronic means. If there is not enough supporting clinical documentation, the review will be sent to a physician reviewer for review. All reviews are based on medical necessity.

Denial of Prior Authorization

- If a UM reviewer determines that the information provided by the provider/facility does not have adequate clinical information to support medical necessity approval, the requested review will be sent to a licensed provider for medical necessity review and peer review.
- The provider completing the peer review will attempt to contact the attending provider at the facility to review the client’s treatment plan and clinical documentation prior to making a denial determination. If the attending provider is not available to talk with the reviewing provider, a determination will be made based on the submitted documentation.
- Denial letters indicating the requested service, reason for denial, and the appeal process will be mailed to the provider, facility, and the client.
- The PA process must be completed within three (3) working days. The time begins when the review request is submitted to Xerox and continues until the facility/provider is notified of the approval or denial via letter or other electronic means.
Appeal Process

The provider, facility and/or client may request an appeal after the initial denial has been issued. Xerox has three (3) working days to make a determination on any appeal from the time it is received.

- After a denial determination is made, the provider may submit a letter of appeal with supporting documentation to Xerox within 20 working days from the date of denial to Xerox. Alternately, the provider may submit a revised request for prior authorization with additional clinical information.

- Once the new information is received, the review will be sent to an outside specialty provider who specializes in medical and behavioral health reviews. For example, a weight loss review would be sent to a provider who specializes in weight loss surgery.

- After the review is completed by the specialty matched provider, the original denial decision will either be upheld or overturned.

- If the decision is overturned, the provider and facility will be notified by letter or other electronic means that the service was approved.

- If the decision is upheld, the provider and facility will be notified that the service requested is denied. In addition, the facility and provider will be notified by letter of the optional Hearing process with WY Medicaid. Either the attending physician or the hospital may request a Hearing process by Medicaid pursuant to the provisions of Chapter 4 of the Wyoming Medicaid Rules and Regulations. The instructions on how to request a Hearing are outlined in the letter sent to the provider and facility.

The denial of a prior authorization precludes Medicaid reimbursement for the services in question.

Failure to Obtain a Timely Prior Authorization

Failure to obtain prior authorization before providing services will result in a denial for late submission and precludes Medicaid reimbursement for such services. Requests for prior authorization should be submitted no less than three (3) working days in advance and no more than five (5) working days in advance of services.
Acute Admissions

A facility must complete and submit the admission form and any supporting documentation within 24 hours of admission for the following inpatient hospital services:

- Acute psychiatric stabilization (including detoxification), adult
- Acute psychiatric stabilization, child/adolescent

If the admission meets medical necessity and is approved, the facility will receive a PA number by the end of the next working day from the submission date.

If the UM clinical evaluator is unable to determine the admission meets medical necessity criteria, the admission request is referred to a physician reviewer.

Continued Stay Reviews

Continued Stay reviews for psychiatric acute admissions are required for clients who remain inpatient on the Last Certified Date (LCD). The facility is required to submit a continued stay review to Xerox for continued authorization until date of discharge. The facility is required to submit a client discharge report at the time of discharge from the facility.

Case Management Services

Case management services are available for clients in the acute setting and will be initiated on a case by case basis. See Case Management services on page 7.

Failure to Obtain Timely Admission Authorization

Failure to obtain admission authorization will result in a denial for late submission and precludes Medicaid reimbursement for such services. Request for PA should be submitted no later than one (1) working day after admission.

Retroactive Eligibility

An acute facility may submit a Retroactive Admission request form for admission authorization for a client found retroactively eligible for Medicaid coverage after the date of admission for services that require PA. See Retrospective Reviews on page 21 for further details.

Admission Authorization Notification

The issuance of an admission authorization notification is not a guarantee of the client’s eligibility for Medicaid payment or a guarantee of Medicaid payment. Designated admissions are subject to continued stay and/or post-payment review pursuant to Chapter 8, Section 8, in the WY Medicaid Rules and Regulations.
Continued Stay Reviews

Continued Stay Reviews (CSRs) are required for client admission to facilitate the most appropriate, cost-effective and timely care for Medicaid clients. The CSR takes place during the time in which a client is confined to the facility. The purpose is to determine if the continued confinement is medically necessary and appropriate.

The following types of admissions are reviewed for continued stays:

- Inpatient Physical Rehabilitation
- Skilled Nursing Extraordinary Care
- Acute Psychiatric Care
- Psychiatric Residential Treatment Facility (PRTF)

Submitting a CSR

Facilities must submit the continued stay review (CSR) form and supporting documentation to Xerox. Items that are identified in the CSR form include:

- clinical rationale for continued stay
- treatment provided,
- progress toward goals, and
- discharge plans.

The Xerox team will identify the date the CSR is due to be submitted for continued authorization. The date of the last covered day (LCD) is when the CSR is required to be submitted to Xerox and will be considered late if the review is not submitted on the LCD. Xerox will notify the facility and/or provider via fax or by the provider portal of each LCD. Failure to complete and submit the required continued stay review on the designated date will result in denial of the remainder of the stay, or a denial of the number of days that the submission was late once a CSR is received and approved.

CSR Determination

The facility will be issued a determination on each CSR. The determination will either be approved or denied. CSRs will continue for approved stays until services are completed and the client is discharged. Failure to notify Xerox of the continued stay will result in a denial, as outlined above.
Extraordinary Care

Wyoming Medicaid provides extraordinary care benefits to clients in a Skilled Nursing Facility with medical conditions defined by the Division of Healthcare Financing, who require special care related to an MDS Activities of Daily Living Sum score of ten (10) or more, or clinically complex care as recognized under the Medicare RUG-III classification system. The extraordinary care benefit also extends to adult clients presenting with a Severe and Persistent Mental Illness (SPMI) with long term psychiatric and behavioral health needs, who exhibit challenging and difficult behaviors and require care that exceeds the scope of traditional skilled nursing facility services. Other medical and mental health conditions with special care needs are evaluated on a case-by-case basis. The services requested are individualized, specific and consistent with symptoms or confirmed diagnosis, and not in excess of the client’s needs. Extraordinary Care requires prior authorization and continued stay reviews at 15 days, 30 days, 90 days, and annually or as needed if medical or psychiatric evaluation demonstrates a change in status. Annual Cost Reviews for extraordinary care clients will be done in conjunction with October 1 rate effective date reviews. The skilled nursing facility submits the required forms and supporting documentation for extraordinary care to Xerox Care and Quality Solutions (Utilization and Care Management) for review of medical necessity. Wyoming Nursing Facility Extraordinary Care Criteria is located in Appendix C and the forms are located in the Appendix A on pages 66-68

Retrospective Reviews

A retrospective review is conducted after services are provided. There are two circumstances that meet the criteria for a retrospective review:

1. An individual was admitted to a facility and received services that require a prior authorization and then, after the admission and services, became eligible for Medicaid.
2. A facility provided services requiring a prior authorization and then became a Medicaid provider and received its provider enrollment number.

Procedure for Obtaining a Retrospective Review

1. An attending physician or a facility cannot seek prior authorization for an individual whose application for Medicaid is pending at the time of admission.
2. The facility must mail the retrospective review form, complete medical record, and proof of notification to Xerox within thirty (30) calendar days after the facility receives notice of client eligibility or provider enrollment number. Failure to request retrospective certification in a timely manner or failure to submit the complete medical records will result in a denial. The address to mail the medical records to is:
   
   Xerox Care and Quality Solutions, Inc.
   PO Box 49
   Cheyenne, WY 82003

3. The date/method of notice of ineligibility and/or end of insurance benefits that was provided to the facility by the primary insurer must be included with the request for review.
Utilization Timeline Requirements

The chart below summarizes the timeline requirements for submission of all utilization management requests. Information submitted for utilization management (UM) reviews should be submitted by fax to 1-888-245-1928 or other electronic method. Xerox does not perform reviews over the telephone.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Submission Timelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Psychiatric / Detoxification</td>
<td>Within 2 working day of admission</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facility</td>
<td>3 to 7 working days in advance of admission</td>
</tr>
<tr>
<td>Physical Rehabilitation</td>
<td>Within 1 working day of admission</td>
</tr>
<tr>
<td>Extraordinary Care SNF</td>
<td>Within 1 working day of admission</td>
</tr>
<tr>
<td>Weight Loss Surgery</td>
<td>No less than 3 working days in advance</td>
</tr>
<tr>
<td>Vagus Nerve Stimulator (VNS) for Epilepsy</td>
<td>No less than 3 working days in advance</td>
</tr>
<tr>
<td>Transplants</td>
<td>If the date of the transplant is not yet determined, the facility may receive prior authorization. The authorization is good for 1 year. When the client is admitted for the transplant the facility has 1 working day to notify Xerox of the actual admission date.</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Within 30 working days of notification of:</td>
</tr>
<tr>
<td></td>
<td>• Client’s eligibility for Medicaid benefits</td>
</tr>
<tr>
<td></td>
<td>• Provider’s eligibility as Medicaid provider</td>
</tr>
<tr>
<td></td>
<td>Facility must provide proof of that notification with submission of request</td>
</tr>
<tr>
<td>Appeals</td>
<td>Within 20 working days of date of denial notice</td>
</tr>
</tbody>
</table>

Random Post Pay Reviews

Xerox is required to conduct random post pay reviews monthly to evaluate medical necessity, appropriateness of level of care, quality of care and under/over or inappropriate utilization of services. This requirement is defined in Chapter 8, Section 13 of the WY Medicaid Rules and Regulations. The reviews are conducted after a client receives treatment in an inpatient or outpatient setting. The following four types of reviews are completed monthly:

- Inpatient Reviews
- Outpatient Reviews
- Hospital Reviews
- Outlier Reviews

Facilities and providers are mailed certified letters requesting complete medical records for specific dates of service to complete the random post pay reviews. Facilities have twenty (20) working days after receiving the initial certified letter to submit the requested medical records to Xerox. It is the responsibility of the provider/facility to confirm that Xerox has received the required documentation. Failure to send the records timely may result in Wyoming Medicaid’s Program Integrity Division recovering overpayment of funds. If you have any questions about the post pay review process or letters, please call Xerox at 1-888-545-1710.
Focused Reviews

Focused reviews are performed at the direction of the Division of Healthcare Financing and may focus on:

- A single facility
- A single provider
- A client procedure
- A category of services

The focused review may be requested to review under and/or improper utilization of services and high-volume services. Xerox requests medical records to complete the review and has access to additional peer review for complicated or specialized focused reviews.

Mortality Reviews

Xerox reviews all Developmentally Disabled Adult Waiver, Developmentally Disabled Child Waiver, Acquired Brain Injury Waiver, and Children’s Mental Health Waiver clients who expire while receiving waiver services. In addition, several Long Term Care, Assisted Living Facility, and Program for All Inclusive Care of the Elderly reviews are being completed. Xerox meets with the mortality committee frequently during the year to discuss services and treatment that was provided to waiver clients. The purpose of the review is to ensure clients are receiving appropriate services and treatment.

Facilities and providers are mailed letters requesting medical records to complete the mortality reviews. Facilities/providers have twenty (20) working days to submit the requested medical records to Xerox when they receive the certified letter. If you have any questions about the mortality review process or letters, please call Xerox at 1-888-545-1710.
3 Psychiatric Residential Treatment Facility

Definition

Psychiatric Residential Treatment Facility (PRTF) is defined as 24-hour, supervised, inpatient level of care provided to children and adolescents up to age 21 who have long-term mental health or psychiatric illnesses and/or serious emotional disturbance(s) that are not likely to respond to short-term interventions and have failed to respond to community based intervention(s).

PRTFs provide comprehensive mental health and substance abuse treatment service to children and adolescents who, due to severe emotional disturbance, are in need of quality, proactive treatment. In addition to diagnostic and treatment service, PRTFs should also provide instruction and support toward attainment of developmentally appropriate basic living skills/daily living activities that will enable children and adolescents to live in the community upon discharge.

The focus of a PRTF is on improvement of a client’s symptoms through the use of evidence-based strategies, group and individual therapy, behavior management, medication management, and active family engagement/therapy; unless evidence shows family therapy would be detrimental to the client. Unless otherwise indicated, the program should facilitate family participation in the treatment planning, implementation of treatment planning, and timely, appropriate discharge planning (which includes assisting the family with varying levels of support and services to ensure a safe, stable and nurturing home environment). This is often referred to as wrap-around services. In effect, it means wrapping a child/family with support until the family reaches an adequate level of self-sufficiency. Wyoming Medicaid provides wrap around services within the Children’s Mental Health Waiver.

Who should be admitted to a PRTF?

A client may be appropriate for admission to a PRTF if he/she has a psychiatric condition that cannot be reversed with treatment in an outpatient treatment setting and the condition is characterized by severely distressing, disruptive and/or immobilizing symptoms which are persistent and pervasive.

Who should not be admitted to a PRTF?

A client who is experiencing acute psychiatric behaviors is not appropriate to be admitted to a PRTF. PRTF services are not the entry point to accessing inpatient psychiatric services for client’s who are in need of an acute level of care.
Prior Authorization for PRTF

Is prior-authorization required for admission to a PRTF?

Yes, prior-authorization is required prior to admission to a PRTF. The facility must submit the completed admission packet to Xerox three (3) to seven (7) days prior to the date of the planned admission.

Xerox admission packets include the following required information:

- Completed admission form (See Appendix A)
- Physician’s order for admission,
- Psychiatric evaluation that has been performed by a child/adolescent psychiatrist,
- Estimated length of stay,
- Viable discharge plan, and
- Any other clinical information that supports the client’s need for admission.

Facilities are allowed up to 14 working days, following the date of admission, to submit the individual plan of care, which must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility. Based on education and experience, preferable including child psychiatry, the team must be capable of:

- Assessing the client’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.
- Assessing the potential resources of the client’s family.
- Setting treatment objectives.
- Prescribing therapeutic modalities to achieve the plan’s objective.

The team must include as a minimum, either,

- Board-eligible or Board Certified psychiatrist.
- Clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- Physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease, and a psychologist who has a Master’s degree in clinical psychology or who has been certified by the State psychological association.

The team must also include one of the following:

- Psychiatric social worker.
- Registered nurse with specialized training or one year’s experience in treating mentally ill individuals.
- Occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- Psychologist who has a master’s degree in clinical psychology or who has been certified by the State or by the State psychological association.
PRTF Length of Stay

The expected length of stay for WY Medicaid clients is no longer than 120 days. *Treatment plans, interventions, medication management, and discharge plans must reflect adherence to this timeline.

*Exception: There may be some instances where a client requires a longer length of stay. This circumstance will be addressed on a case-by-case basis.

PRTF Admission Criteria

What are the criteria for admission (ADM) to a PRTF?

The following outlines the PRTF Admission Criteria. The client must meet all five.

1. The client presents with a longstanding (at least six months) psychiatric diagnosis characterized by severely distressing, disruptive and/or immobilizing symptoms that are persistent and pervasive and which cannot be reversed with treatment in an outpatient treatment setting, or is being stepped down in intensity from an acute psychiatric facility. The diagnosis must meet the criteria for an Axis 1 as defined by the current edition of the DSM.

   Examples would include the following:
   a. The presence of emotional distress.
   b. Regression, depression, low frustration tolerance, irritability and/or other psychiatric symptoms that interfere with the client's ability to change behavior and/or mood, form a therapeutic alliance or sustain engagement in treatment.
   c. Impaired reality testing.
   d. A condition consistent with an eating disorder diagnosis as described in the current edition of the DSM.

2. There are documented attempts to treat the client with the maximum intensity of services available at a less intensive level of care that cannot meet or has failed to meet the needs of the client within the past six months. The client must have failed to respond to outpatient interventions. Six months of alternative, less restrictive levels of care must have been tried and have failed, or are not psychiatrically indicated.

   Exception: The client has had a sudden, acute onset of psychiatric illness, and a lower level of care is not psychiatrically indicated.

3. At least one of the patterns of behavior listed below must be present:
   a. Persistent, pervasive and frequently occurring oppositional/defiant behavior.
   b. Reckless and/or impulsive behavior, which represents a disregard for the well-being and/or safety of self/others.
   c. Aggressiveness and/or explosive behavior.
   d. Gestures with intent to injure self/others, which have not resulted in serious injury, without evidence that such gestures are immediately progressing to life threatening behavior.
   e. Self-induced vomiting, use of laxatives/diuretics, strict dieting, fasting and/or vigorous exercise.
   f. Extreme phobic/avoidant behavior.
g. Extreme social isolation.
h. History of repeated life threatening injury to self/others, resulting in acute care admissions within the past 12 months. The client is not currently considered at risk to inflict life-threatening injury to self/others in the residential treatment setting.

4. Without intervention, there is clear evidence that the client will likely decompensate and present a risk of serious harm to self or others.

5. A psychiatric evaluation by a child/adolescent psychiatrist. The child/adolescent psychiatrist must be licensed and in good standing. The evaluation must take place no more than 30 days prior to PRTF Admission.

What are the required items to be completed in the admission form?

1. Initial diagnostic assessment.
2. Medical, psychiatric and substance use history.
3. Family and social assessment.
4. Client assets and strengths.
5. Developmental history and current developmental functioning with respect to physical, psychological and social areas, including age-appropriate adaptive functioning and social problem-solving.
6. Psycho-educational assessment.
7. An assessment of the need for psychological testing, neurological evaluation and speech, hearing and language evaluations.
8. A problem list, related to the reasons why the client was admitted to this level of care.
9. Identification of interventions for the immediate management of the problems identified in Criteria number 3, letter h.
10. The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review.

Continued Stay Reviews for PRTF

What must be submitted to Xerox during the first Continued Stay Review (CSR)?

The following must be submitted to Xerox during the first CSR:

1. The first CSR form must be submitted to Xerox within 14 days of admission.
2. A psychiatric evaluation completed by the facility psychiatrist.
3. If the client is court-ordered to the facility, a copy of the court-order paperwork must accompany the submission of the CSR form.
What are the criteria for a CSR at a PRTF?

1. The client continues to display a pattern of disturbance of thought, affect, adaptation and/or behaviors which are related to his/her psychiatric condition and requires 24 hour supervision.

2. Symptoms present at admission persist but are responding to treatment and/or a change in level of functioning occurs and/or a new problem/diagnostic aspect is discovered requiring ongoing treatment.

3. All therapies and activities outlined in the individualized treatment plan are provided within specified timeframes and reviewed by the interdisciplinary team.
   a. The facility shall identify the interventions and treatment modalities that are being used to address each of the client's identified problem areas. The provider must indicate through documentation the progress that is being made by describing intended outcomes and actual outcomes.
   b. Interventions set to achieve objectives and goals within each reporting period must be concrete, realistic and measurable. Progress reports on all goals are required. If a goal is changed or not met, a clinical explanation as well as adjustments to the treatment plan must be documented and provided in the continued stay review.
   c. Each client must have a designated treatment team that may include, but is not limited to: a psychiatrist, therapist, nurse, parent(s), guardian(s), family care coordinator (FCC), clients, program managers, Xerox, teachers, Guardian Ad Litem (GAL) Department of Family Services (DFS) representative and outdoor/recreational specialist.
   d. The client must demonstrate the ability and capacity to respond favorably to therapeutic intervention. If the client refuses to participate in treatment, is not responding to treatment, or is decompensating over time despite therapeutic intervention, alternative facilities may be considered. Clients who exhibit the aforementioned may be sent to a peer review for discussion and/or determination.
   e. Individual Therapy must take place a minimum of one (1) hour per week, however two sessions per week for one hour each session is recommended.
      *Exception: If a client is unable to maintain during the session for an hour at a time, sessions may be broken up throughout the week into smaller time frames so that the total weekly time for individual therapy is not less than one (1) hour.
   f. Family therapy must take place once a week for at least one (1) hour.
      *Exception: If a client is unable to maintain during the session for an hour at a time, sessions may be broken up throughout the week into smaller timeframes so that the total weekly time for family therapy is not less than one (1) hour.

4. Discharge planning is continuous and involves the client and family/guardian.
   a. It is expected that a child/adolescent's primary psychiatric condition will be stabilized within four months of PRTF level of care. It is in the best interest of the client to be treated in the least restrictive environment. When a client no longer meets PRTF criteria for inpatient status, the appropriate transfer or discharge plans must immediately be implemented. This may include but is not limited to: discharge to home or to local home area which includes assistance from outpatient wrap around services, Residential Treatment Center (RTC), group home, and/or therapeutic foster home.
   b. Discharge planning must begin at admission. Even if the discharge plan has to be updated each month, the facility and guardian(s) must know where the child/adolescent would go if they had to discharge immediately for any reason. Xerox may send a request for admission or for continued stay to peer review for lack of discharge planning.
c. If a facility states a client has reached his/her maximum therapeutic benefit, or the client has plateaued in his/her treatment, then the facility must work with Xerox and any other members of the treatment team to identify appropriate alternative placement.

d. A discharge summary must be sent to Xerox within 30 days of discharge from a PRTF. Discharge summaries must also be sent to the client's community providers, the family care coordinator (FCC) and the school the client attends post-treatment.

e. Clients must discharge from a facility with both a 7-day and a 30-day follow up appointment with a mental health provider. It is the responsibility of the facility to assist the client with discharge planning and appointments. The appointment, including the date, time and provider, must be listed on the discharge summary.

f. Clients must discharge with prescriptions for their currently prescribed medication. Clients who are not supplied with prescriptions must be supplied with sufficient medication to sustain them until their first scheduled medication management appointment. Medications and/or prescriptions sent with the client must be listed on the discharge summary.

What items are required to be addressed for a Continued Stay at a PRTF?

(See CSR Form in Appendix A)

1. The treatment team has completed the essential admission assessment and developed an interdisciplinary treatment plan.

2. An interdisciplinary treatment plan must contain:
   a. A list of problems related to the reason for admission.
   b. A list of treatment modalities to address identified problems.
   c. A description of measurable treatment objectives, expected within the next review interval, which will indicate progress in achieving discharge goals.
   d. A description of the discharge goals with an estimated discharge date.
   e. A description of any special therapeutic assistance, if required to help the client achieve treatment objectives.
   f. A description of the family services to be provided. It is expected that family of clients will be available to comply with family therapy for at least one full hour per week that address the following:
      i. Identification of any family issues which require stabilization.
      ii. Identification of factors which may have created a crisis in the family and/or exacerbated the client’s psychiatric condition must be provided.
      iii. Education for the family/primary caretakers regarding the client’s condition and/or developing ways to support the client’s progress in treatment.
      iv. Description of the changes in the client and family responses required before the client can safely be discharged to the home setting.
      v. A schedule for providing family services with the frequency necessary for the timely achievement of treatment objectives and discharge goals.
      vi. There may be occasions when family therapy is contraindicated for psychological reasons. In such instances, provisions should be made for helping the child deal with any psychological trauma caused by this situation.
vii. When a return to the family/primary caretakers is not going to be possible, alternative placement and discharge planning arrangements should begin at the earliest possible date.

viii. There may be occasions where the family expresses unwillingness to be involved with the child in therapy or after discharge. In such instances, each case will be dealt with on an individual basis.

3. Assessment which identifies the treatment objectives which have been achieved at this point in treatment and the discharge goals remaining to be achieved at this level of care.

4. Client Condition Summary:
   a. The treatment objectives which have not been achieved as expected at this point in treatment.
   b. Factors interfering with the client’s ability to meet treatment objectives.
   c. The continuing appropriateness of the current treatment objectives.
   d. The continuing appropriateness of the modalities and interventions selected.
   e. There is a description of measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals.

5. Discharge Planning: A summary that includes an assessment of problem areas related to maintaining improvement achieved at this level of care, and arrangements for appropriate therapeutic services following discharge to assist the client in maintaining improvement achieved at this level of care. In addition, documentation must indicate active planning identifying wrap around services in the community.

How will the PRTF know when the CSR is due?

Xerox will provide the PRTF a Prior Authorization (PA) number if the admission meets medical necessity. In addition, Xerox will notify the facility when the next CSR form is due. The number of days approved may vary from one to thirty (30) days depending on the clinical presentation of the child/adolescent and also on the facility documentation and compliance with submitting all items listed above under “What is Required for a CSR.”

What is Peer Review?

If the Xerox utilization reviewer cannot make a medical necessity decision based on clinical information submitted for review, the review is sent to a psychiatrist/physician reviewer. It is a Utilization Review Accreditation Commission (URAC) requirement that the Xerox utilization reviewer cannot deny a review based on medical necessity. A denial can only be determined by a psychiatrist or physician with current credentials and experience in behavioral health. Xerox has psychiatrist reviewers and also contracts with child/adolescent psychiatrists and physicians as needed to complete behavioral health reviews.

Can a Residential Treatment Center (RTC) request a PA for a Medicaid Client?

Medicaid cannot reimburse RTCs for room and board services. Please call Provider Relations at 1-800-251-1268 if there are questions on what fees can be submitted for reimbursement.
Can a PRTF request Therapeutic Passes?

A facility can request a therapeutic pass. Xerox should be notified of all therapeutic passes prior to the planned leave of absence. Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of Medicaid clients less than twenty-one (21) years of age at the regular per diem rate when all the following conditions are present:

1. A therapeutic leave of absence must be for therapeutic reasons as prescribed by the attending psychiatrist/physician and as indicated in the client’s habilitation plan.
2. A physician’s order for therapeutic leave must be maintained in the client’s file at the facility.
3. The total length of time allotted for therapeutic leave of absence in any calendar year shall be fourteen (14) days. If the client is absent from the PRTF for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that client in that year.
4. In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid clients when the facility has an occupancy rate of less than ninety percent (90%). The occupancy rate is based on the total number of licensed beds. The PRTF is required to submit verification that the occupancy rate was at 90% or higher during any therapeutic leave of absence in order to obtain reimbursement for those days. If the bed rate is less than 90%, the facility shall bill therapeutic leave days as non-covered days which are not eligible for reimbursement.

Are care management services available for Medicaid Clients in PRTFs?

Yes. Care Management services is available to all WY Medicaid clients in a PRTF. Please call 1-888-545-1710 to refer a client to care management services or complete a CSQ referral form and fax it to Xerox at 1-888-245-1928. Or, you can obtain a referral form from the Xerox website at www.wyhealth.net under forms.

What is the role of the Xerox Behavioral Healthcare Manager?

The role of the care manager is to assess the needs and potential needs of the client by gathering clinical information and coordinating efforts with different entities. These may include the parent/guardian, Department of Family Services (DFS) worker, guardian ad litem (GAL), facility, provider, therapist, etc. The care manager coordinates input from the different entities to facilitate appropriate support services and discharge planning. In addition, the care manager collaborates with the Children’s Mental Health Waiver to ensure clients follow up services after discharge.

How are court ordered youth cases handled?

Youth in PRTF level of care in and outside of Wyoming may be under court order. The admission and continued stay review process is the same for these youth. Xerox care managers maintain close contact with facilities, DFS, and the family through phone and email contact to communicate during the admission, continued stay, and discharge transition periods. Xerox allows DFS and facilities up to 30 transitional days for a youth who is approaching a lower level of care. This allows DFS time to schedule appropriate MDT or other judicial meetings. This proactive approach was designed to assist with seamless transitions and avoid sudden expectations of discharge. If a youth does not discharge within the provided transitional days and medical necessity is not being met, the case will be sent to peer review. If the case is not approved for Medicaid funding following peer review, the court ordered youth’s funding source will transition to state general funds. Additionally, in some instances the youth may require continued residential treatment at the RTC level, which is not a service covered by Wyoming Medicaid; RTC level of care is paid for by DFS directly.
What are the expectations at the time of discharge from a PRTF?

It is expected that the discharge plan has been discussed and reviewed by the treatment team at the facility, Xerox, the parent/or guardians/foster parents and any other care providers such as waiver case worker. The discharge plan should be viable and well thought out for successful discharge. The parents/guardians should be actively involved in developing the discharge plan and follow-up services. A typical discharge plan should include the following:

1. The initial follow-up appointment must be scheduled with a counselor/therapist, doctor or other provider to occur within seven days of discharge.
2. Availability of a provider for follow-up treatment who will continue treatment and management.
3. Medication list of prescription refills to be obtained at a local pharmacy.
4. A safety plan will be in place, including instructions of who and when to call if behaviors escalate or become out of control.
5. Names and phone numbers for resources available to the client/family.
6. Referral to the Children’s Mental Health Waiver or community mental health programs for additional support and services, as appropriate

Are facilities required to complete the Xerox Admission Form if the client has other insurance?

The answer is yes. Facilities are required to complete the prior authorization process in instances where the client has other insurance with another carrier. If prior authorization is not obtained and the primary carrier does not reimburse for the services, Medicaid may deny the claim due to lack of prior authorization.
4 Inpatient Census Report (ICR)

All enrolled WY Medicaid acute facilities are required to provide an Inpatient Census Report (ICR) to Xerox every week by Friday at 5:00 pm. This requirement complies with the specifications located in Chapter 29, Section 5 of the Wyoming Medicaid Rules and Regulations. If a facility does not comply with this requirement, a first warning letter will be mailed to them from Xerox reminding them of the weekly requirement. A second warning letter will be mailed to the facility if continued non-compliance continues and a copy of the letter will also be mailed to the Program Integrity Division of the Department of Healthcare Financing. If there is no improvement in compliance, Wyoming Medicaid payments to the facility may be held until demonstrated compliance.

ICR Requirements

1. ICRs are required to be submitted by all acute, medical, and psychiatric inpatient facilities by fax at 1-888-245-1878, secure e-mail to Miranda.salieb@xerox.com of future web portal no later than 5:00 PM on Friday of each week. If Friday is not a working day, the ICR must be submitted by 5:00 PM on the preceding working day.

2. Contact names and telephone numbers for your facility must be accurate.

Weekly ICR reports must contain all requested information per the Inpatient Census Report template. The list below identifies the data that is required weekly.

- Client Name
- Client Address
- Client County
- Client Phone
- Client DOB
- Client Medicaid ID number
- Client Diagnosis
- Client Admission Date
- Client Discharge Date
- Client Physician
- ER/Direct Admission
- Comments (death, left against medical advice, transfers to another facility, etc.).

Xerox makes weekly contact with the case manager/discharge planners to review care coordination services for clients who have increased discharge needs. Facilities can call Xerox for assistance with complicated discharge or coordination needs by calling 1-888-545-1710.
5 Utilization Management Forms
Appendix A
**Acute Inpatient Psychiatric Admission Authorization**

Authorization **DOES NOT** guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

**Timelines for clinical information to be faxed to Xerox:**
**Acute Care Admissions:** One (1) Working Day for the date of admission

Attending Physician (first and last name):
Physician Address:          Physician Phone #:

**CLIENT INFORMATION**

Name:          Medicaid ID#:
Address:       Phone #:
DOB:          Age:          SS#:          Sex: Male Female
Language Spoken:
Who is patient’s Legal Guardian?      Guardian Phone #:
Guardian’s Address:
Parent's Name:          Parent Phone #:
Is client in DFS Custody?    Yes No
If yes, who is patient’s DFS worker/Probation Officer? Phone #
Is this admission court ordered? Yes No **If yes, please provide court order paperwork**
GAL Name:          GAL Phone #:
Type of Admission (circle one)  Voluntary / Involuntary
Title 25: Yes No
Previous Facility Admission(s): Yes No
Facility Name:
Admission Date: Discharge Date

**DSM IV code(s) (provide ALL code numbers as well as diagnosis names)**
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

**Clinical:**
Precipitating event and information / signs & symptoms (including mental status exam): Why is patient being admitted to this facility?

What are the emotional and behavioral problems that require highly structured 24 hour therapeutic environment?

Treatment History: previous providers and placements, medication trials, current providers, history of SI/HI, attempts & self harm behaviors. Alternative placements or community based services tried in the past year.

Substance use/abuse issues:

Abuse History:

Abuse was reported to: When:
If abuse was not reported, explain why:

Family/Social history (including history of Psych & CD issues in the family):

Medications ordered on Admission (Dosages & frequency; for PRN meds, specify reason and how often used):

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Initial treatment plan (include level of observation/interventions):
Discharge Plan

1. Who is the patient being discharged to?

2. What is the safety plan for discharge?

3. Are outpatient services in place? If not, please explain why.

4. Does the patient have a 7 day follow-up appointment with a mental health practitioner?

5. Does the patient have a 30 day follow-up appointment with a mental health practitioner?

6. Barriers to discharge (please check all that apply):
   
   a. _____Discharge treatment setting not available
   b. _____Adequate housing
   c. _____Treatment non-compliance
   d. _____Transportation
   e. _____Lack of community supports
   f. _____Other (specify)

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Acute Inpatient Psychiatric Continued Stay review

Required Documentation: □ Treatment Plan □ Completed Continued Stay Form

Authorization DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be faxed to Xerox:
In order to avoid gaps in coverage, the CSR MUST be received on the last covered day.

Attending Physician’s Name: Primary Care Physician (PCP) Name:
Physician Address:           Physician Address:
Physician Contact #:         Physician Contact #:
Has PCP been notified? Yes  No

Was this admission court ordered? Yes  No
Is this a General Fund review? Yes  No

Current Guardian name and phone #:
Parent current phone #:

CLIENT INFORMATION

Name: Medicaid ID:
DOB: Age:
Current DSM IV code(s) (provide ALL code numbers as well as diagnosis names) Include any changes since admission.

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

What is the clinical rationale for continued stay at the current level of care since the last review (i.e. med changes, progress made, continued progress needed, changes in approach, objective focus, progress/issues in group, school, milieu, individual therapy)?

Interdisciplinary Treatment Plan

List of problems related to the reason for admission:

List of treatment modalities to address identified problems – Include progress and/or difficulties observed in Group Therapy, Individual Therapy, and Milieu summary:

Provide an update on the treatment objectives which has been achieved at this point in treatment description of the measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals:

Describe the discharge goals remaining to be achieved at this level of care:

Provide a description of any incidents of time outs, seclusion, restraints, aggression, etc.:

Medications (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10.
Discharge Plan

1. Who is the patient being discharged to?

2. What is the safety plan for discharge?

3. Who is providing medication management services (Name/Phone #)

4. Who is providing outpatient therapy (Name/Phone #)

5. Does the patient have a 7 day follow-up appointment with a mental health practitioner?

6. Does the patient have a 30 day follow-up appointment with a mental health practitioner?

7. Barriers to discharge (please check all that apply):
   a. _____ Discharge treatment setting not available
   b. _____ Adequate housing
   c. _____ Treatment non-compliance
   d. _____ Transportation
   e. _____ Lack of community supports
   f. _____ Other (specify)

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Involuntary/Title 25 admissions are not a covered benefit with WY Medicaid. This form is only to be completed for involuntary admissions. If a patient becomes voluntary, the standard acute inpatient psychiatric admission authorization form must be submitted for medical necessity review.

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be faxed to Xerox:

Acute Care Admissions: One (1) Working Day for the date of admission

Attending Physician (first and last name):
Physician Address: Physician Phone #:

CLIENT INFORMATION

Name: Medicaid ID#:
Address: Phone #:
DOB: Age: SS#: Sex: Male Female
Language Spoken:
Who is patient's Legal Guardian? Guardian Phone #:
Guardian's Address:
Parent's Name: Parent Phone #:
Is client in DFS Custody? Yes No
If yes, who is patient's DFS worker/Probation Officer? Phone #
Is this admission court ordered? Yes No If yes, please provide court order paperwork
GAL Name: GAL Phone #:
DSM IV code(s) (provide ALL code numbers as well as diagnosis names)
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Clinical:
Precipitating event and information / signs & symptoms (including mental status exam): Why is patient being admitted to this facility?

What are the emotional and behavioral problems that require highly structured 24 hour therapeutic environment?

Medications ordered on Admission (Dosages & frequency; for PRN meds, specify reason and how often used):
6. 
7. 
8. 
9. 
10. 

Projected discharge date:

Are follow-up outpatient services in place? If so, what are they?

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Psychiatric Residential Treatment Facility
Admission Authorization

Required Documentation:
- □ Completed Admission Form
- □ Physician Order for Admission
- □ Viable Discharge Plan
- □ Psychiatric Evaluation

Authorization DOES NOT guarantee payment or client eligibility.

<table>
<thead>
<tr>
<th>Required Documentation</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Requested:</td>
<td></td>
</tr>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be faxed to Xerox:
PRTF Admissions: Three (3) to seven (7) calendar days prior to admission date

Attending Physician (first and last name):  
Physician Address:  
Physician Phone #:

CLIENT INFORMATION

Name:  
Address:  
DOB:  
Age:  
SS#:  
Sex: M / F  
Language Spoken:

Who is patient’s Legal Guardian?  
Guardian’s Address:  
Guardian Phone #:

Parent’s Name:

Is client in DFS Custody?  Yes  No
If yes, who is patient’s DFS worker/Probation Officer?  
Phone #:

Is this admission court ordered?  Yes  No  If yes, please provide court order paperwork
GAL Name:  
GAL Phone #:  

44
Primary Care Provider (PCP) Name:
Has client visited PCP in the last year: Yes  No
Previous Facility Admission(s): Yes  No
Facility Name:
Admission Date:  Discharge Date

DSM IV code(s) (provide ALL code numbers as well as diagnosis names)
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Clinical:
Precipitating event and information / signs & symptoms (including mental status exam): Why is patient being admitted to this facility? Emotional and behavioral problems requiring highly structured 24 hour therapeutic environment:

Treatment history (Documentation of failed response to outpatient and inpatient interventions within the past 6 months, previous providers and placements, medication trials, current providers, history of SI/HI, attempts & self harm behaviors. Alternative placements or community based services tried in the past year.)

Substance use/abuse issues:
Abuse History:
Abuse was reported to:  When:
If abuse was not reported, explain why:

Client strengths and weaknesses (include support system):

Family / Social history (include history of Psych & CD issues in the family):

Who has been identified to participate in the required weekly family therapy sessions?:

Reasons treatment cannot be provided in the community:
Medications (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10.

Initial treatment plan (include level of observations/interventions):

The treatment objectives (desired client responses) expected to be met by the time of the first continued stay review:

If applicable, an assessment of the need for psychological testing, neurological evaluation and speech hearing and language evaluations.

What local support services have been identified and contacted?:

Discharge Plan

1. Are wrap around services in the community being explored?

2. Who is the patient being discharged to?

3. If the client is being transferred to a lower level of care (RTC, Group Home) please identify facility name and phone number:

   If yes, has the provider been notified?

4. What is the safety plan for discharge?

5. Are outpatient services in place? If not, please explain why.

6. Does the patient have a 7 day follow-up appointment with a mental health practitioner?

7. Does the patient have a 30 day follow-up appointment with a mental health practitioner?
8. Barriers to discharge (please check all that apply):

   a. _____ Discharge treatment setting not available
   b. _____ Adequate housing
   c. _____ Treatment non-compliance
   d. _____ Transportation
   e. _____ Lack of community supports
   f. _____ Other (specify)

Resources

   a. **Uplift**: Main Office Phone #: 888-875-4383
      Website: [www.upliftwy.org](http://www.upliftwy.org)

   b. **Child Mental Health Waiver**: Main Office Phone #: 307-777-6494
      Website: [http://www.health.wyo.gov/mhsa/treatment/waiverindex.html](http://www.health.wyo.gov/mhsa/treatment/waiverindex.html)

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Psychiatric Residential Treatment Facility
Continued Stay Review

Required Documentation: □ Treatment Plan □ Completed Continued Stay Form

Authorization DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be faxed to Xerox:
In order to avoid any gaps in coverage, the CSR MUST be received on the last covered day.

Attending Physician’s Name: Primary Care Physician (PCP) Name:
Physician Address: Physician Address:
Physician Contact #: Physician Contact #:
Was this admission court ordered? Yes No
Is this a General Fund review? Yes No
Has PCP been notified? Yes No

Current Guardian name and phone #:
Parent current phone #:
Therapist name and phone #:
GAL name and phone #:

CLIENT INFORMATION

Name: Medicaid ID:
DOB: Age:
Current DSM IV code(s) (provide ALL code numbers as well as diagnosis names) Include any changes since admission.

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

What is the clinical rationale for continued stay at the current level of care since the last review (i.e. med changes, progress made, continued progress needed, changes in approach, objective focus, progress/issues in group, school, milieu, individual therapy)?

Interdisciplinary Treatment Plan

List of current treatment targets, as related to the reason for admission:

List of treatment modalities to address identified problems – Include progress and/or difficulties observed in Group Therapy, Individual Therapy, and Milieu summary:

Provide an update on the treatment objectives which has been achieved at this point in treatment description of the measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals:

Provide the measurable treatment objectives expected to be achieved within the next review interval:

If progress is not being made, what changes in treatment plan will be implemented this next review interval? If child has been in PRTF longer than 120 days, indicate if second opinion has been initiated.

Provide a description of any incidents of time outs, seclusion, restraints, aggression, etc.:

Individual therapy: Please indicate dates, frequency, and summary of individual therapy:

Family therapy: Please include names of those participating, goals, dates of each session and how it supports the discharge plan. (PRTF family therapy must be at least one full hour per week):

Onsite visits: Please include names of family participating in onsite visit, dates onsite is to occur, mode of transportation (if known). (Ensure family is aware that participation in family therapy must occur daily while onsite to avoid jeopardizing travel reimbursement.)
Therapeutic passes: Please indicate all dates the patient was out of the facility overnight and note whether your bed rate was over 90% for those dates:

Medications (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Discharge Plan

1. Are wrap around services in the community being explored?

2. Who is the patient being discharged to?

3. If the client is being transferred to a lower level of care (RTC, Group Home) please identify facility name and phone number:

   If yes, has the provider been notified?

4. What is the safety plan for discharge?

5. Who is providing medication management services (Name/Phone #)

6. Who will be providing outpatient therapy (Name/Phone #)

7. Does the patient have a 7 day follow-up appointment with a mental health practitioner?

8. Does the patient have a 30 day follow-up appointment with a mental health practitioner?

9. Barriers to discharge (please check all that apply):
   a. Discharge treatment setting not available
   b. Adequate housing
   c. Treatment non-compliance
   d. Transportation
   e. Lack of community supports
   f. Other (specify)
Resources

a. **Uplift**: Main Office Phone #: 888-875-4383  
   Website: [www.upliftwy.org](http://www.upliftwy.org)

b. **Child Mental Health Waiver**: Main Office Phone #: 307-777-6494  
   Website: [http://www.health.wyo.gov/mhsa/treatment/waiverindex.html](http://www.health.wyo.gov/mhsa/treatment/waiverindex.html)

Fax completed form to Xerox toll free @ 1-888-245-1928  
Forms can be found online at [www.wyhealth.net](http://www.wyhealth.net)
PRTF and Acute Behavioral Health Discharge

Client Name:  
Client DOB:  
Client Medicaid ID #:  
Facility  
Facility UR Rep:  
Facility Rep Phone #:  
Admission Date:  
Discharge Date:  
Discharge Location (where/with whom):  
Discharge Address:  
Discharge Phone #:  

Therapist Follow-up:
Does the client have a 7 day follow-up appointment with a mental health practitioner? Yes  No
If yes, please list name, phone number, date and time of appointment:
If no, please list reason:

Does the client have a 30 day follow-up appointment with a mental health practitioner? Yes  No
If yes, please list name, phone number, date and time of appointment:
If no, please list reason:

Discharge Medications (with dosages/frequency):
1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  

Medication Management Follow-up:  (provider with appointment date and time)

Community Collaboration:  To whom did facility send discharge information to ensure success in the community? What information was sent?

OP Providers:
School/Uplift/Children's Mental Health Waiver:
Other:

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Transplant Service(s)  
Prior Authorization

Authorization **DOES NOT** guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Dates Approved:</td>
</tr>
<tr>
<td>Provider NPI#:</td>
<td>Denied:</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>Procedure:</td>
</tr>
<tr>
<td>Contact Phone #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Contact Fax #:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

**Timelines for clinical information to be faxed to Xerox:**

**Transplant Authorization:** If the date of the transplant is not yet determined, the facility may receive prior authorization. The authorization is good for 1 year. When the client is admitted for the transplant the facility has 1 working day to notify Xerox of the actual admission date.

Attending Physician (first and last name):
Physician Address:  
Physician Phone #:

**CLIENT INFORMATION**

Name:  
Medicaid ID#:
Address:  
Phone #:
DOB:  
Age:  
SS#:  
Sex: M / F

Type of Transplant:  
Date of disease onset:

Procedure description and CPT code(s):

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1.  
2.  
3.  
4.  
5.  
6.
Medical Necessity
Submit information from primary transplant physician including the following:
- Diagnosis per transplant specialist evaluation
- Clinical indications for procedure
- Medical history including comorbidities
- Prognosis with and without transplant
- Plan of care
- Medical and/or surgical management of diagnosis including alternative therapies
- Statement of patient’s ability to adhere to a disciplined medical regimen
- Facility Patient Selection Criteria

Facility Information
Transplant Center Name: Transplant Center Phone#: 
Transplant Center Address:

Physician Information
List ALL physicians who will be involved in the care of the transplant patient.

Medical Physician Name: Physician Phone #: 
NPI #:

Transplant Surgeon Group Practice: Group Practice Phone #: 
NPI #:

Transplant Surgeon Name: Transplant Surgeon Phone #: 
NP I#:

Assistant Surgeon Name: Assistant Surgeon Phone #: 
NPI #:

Other Physician Name: Other Physician Phone #: 
NPI #: 

Other Contacts
Transplant Coordinator Name: Coordinator Phone #:

Transplant Nurse Name: Nurse Phone #:

Financial Information
Financial Contact Name: Financial Contact Phone #:

Insurance Information
Other insurance (including Medicare) precertification obtained? Yes No Not Required
Does client have Medicare? Yes No
   If yes, does client have Part A? Yes No
       Part B? Yes No

Medicaid is considered the payer of last resort. If no prior authorization is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to the lack of prior authorization.

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
# Vagus Nerve Stimulator (VNS) for Epilepsy

**Prior Authorization**

Authorization **DOES NOT** guarantee payment or client eligibility.

<table>
<thead>
<tr>
<th>Date Requested</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Date</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Provider:</td>
<td>Approved:</td>
</tr>
<tr>
<td>Provider NPI#:</td>
<td>Denied:</td>
</tr>
<tr>
<td>Contact Person Name</td>
<td>Procedure:</td>
</tr>
<tr>
<td>Contact Phone #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Contact Fax #:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

*The facility has agreed to share the status of the authorization with the physician and client.*

**Timelines for clinical information to be faxed to Xerox:**

**VNS Authorization:** No less than three (3) working days in advance

Attending Physician (first and last name):

Physician Address: 

Physician Phone #:

### CLIENT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone #:</td>
</tr>
<tr>
<td>DOB:</td>
<td>Age:</td>
</tr>
<tr>
<td>SS#:</td>
<td>Sex: M / F</td>
</tr>
</tbody>
</table>

Procedure description and CPT code(s):

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. 4.
2. 5.
3. 6
Medical Necessity
Submit supporting documentation to include the following:

- Physician statement confirming diagnosis
- Detailed medical history including other diagnoses besides epilepsy
- Quality of Living Assessment (QOL)
- Other therapies tried including anti-epilepsy medication trials and surgeries
- Clear explanation of the need for VNS in patients under 12 years of age
- Clear explanation of why VNS is more appropriate than other methods of treatment for seizures that are not partial onset seizures.

Physician Information
List ALL physicians who will be involved in the care of the patient.

Neurosurgeon Name:  Neurosurgeon Phone #:
NPI #:

Neurosurgeon Group Practice Name:  Practice Phone #:
NPI #:

Neurologist Name:  Neurologist Phone #:
NPI #:

Other Physician Name:  Other Physician Phone #:
NPI #:

Other Contacts
Other Contact Name:  Other Phone #:
Other Relationship:

Financial Information
Financial Contact Name:  Financial Contact Phone #:
Insurance Information
Does the client have other insurance? Yes No
   If yes, name of company and OED:
Other insurance (including Medicare) precertification obtained? Yes No Not Required
Does client have Medicare? Yes No
   If yes, does client have Part A? Yes No
       Part B? Yes No

Medicaid is considered the payer of last resort. If no prior authorization is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to the lack of prior authorization.

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Weight Loss Surgery
Prior Authorization

Authorization **DOES NOT** guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Provider:</td>
<td>Approved:</td>
</tr>
<tr>
<td>Provider NPI#:</td>
<td>Denied:</td>
</tr>
<tr>
<td>Contact Person Name:</td>
<td>Procedure:</td>
</tr>
<tr>
<td>Contact Phone #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Contact Fax #:</td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

*The facility has agreed to share the status of the authorization with the physician and client.*

**Timelines for clinical information to be faxed to Xerox:**
Weigh Loss Surgery: No less than three (3) working days in advance

Attending Physician (first and last name):
Physician Address: 
Physician Phone #:

**CLIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Medicaid ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone #:</td>
</tr>
<tr>
<td>DOB:</td>
<td>Age:</td>
</tr>
<tr>
<td>SS#:</td>
<td>Sex: M / F</td>
</tr>
</tbody>
</table>

Procedure description and CPT code(s):

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. 4.
2. 5.
3. 6.
Medical Necessity
Submit information from primary bypass physician including the following:

- Primary diagnosis and obesity-related co-morbidity(ies)
- Medical history including height, weight, and BMI
- Statement of patient’s ability to adhere to a disciplined medical regimen
- Six month record of physician-supervised diet and exercise program
- Prognosis with and without bariatric surgery
- Plan of care pre and post op

Physician Information
List ALL physicians who will be involved in the care of the bariatric patient.

Surgeon Group Practice Name: Surgeon Group Practice Phone #:
NPI #: 

Surgeon Name: Surgeon Phone #:
NPI #: 

Assistant Surgeon Name: Assistant Surgeon Phone #:
NPI #: 

Other Physician Name: Other Physician Phone #:
NPI #: 

Other Contacts
Primary Care Physician Name: Primary Care Physician Phone #:
Registered Dietician Dietician Phone #:
Clinical Psychologist/Psychiatrist Name: Clinician Phone #:
Physical Therapist Name: Physical Therapist Phone #:

Financial Information
Financial Contact Name: Financial Contact Phone #:
**Insurance Information**

Other insurance (including Medicare) precertification obtained?  Yes  No  Not Required

Does client have Medicare?  Yes  No

  If yes, does client have Part A?  Yes  No
  Part B?  Yes  No

*Medicaid is considered the payer of last resort. If no prior authorization is obtained from Medicaid and the primary insurance carrier does not reimburse, Medicaid may deny the claim due to the lack of prior authorization.*

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Physical Rehabilitation
Admission Authorization

Authorization DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>UR Rep Name:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td></td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be faxed to Xerox:
Physical Rehabilitation: One (1) Working Day from the date of admission

Attending Physician (first and last name):
Physician Address:               Physician Phone #:

CLIENT INFORMATION

Name: Medicaid ID#
Address: Phone #:
DOB: Age: SS#: Sex: Male Female

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):
1. 4.
2. 5.
3. 6

Please attach current multi-disciplinary team notes.

Rehabilitation consult completed? Yes No (Please include a copy)

Reason for rehabilitation / type of injury (date)

Rehabilitation will help restore to his/her max function or independence? Yes No
Medically stable and able to endure active participation in at least three (3) hours of therapy per day, five (5) days per week?  Yes  No

Ranchos Amigos scare of at least five (5)?  Yes  No  List level:

Will receive two (2) modalities of therapy 5-6 days per week?  Yes  No

Required close daily medical supervision by physicians, 24 hour rehab nursing and/or other services?  Yes  No

Participate in interdisciplinary team meetings:  Yes  No

List day of week and frequency:

Include treatment plan based on measured goals and realistic expectations.

Member will discharge home/skilled nursing facility/return to lower level of care?  Yes  No

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
### Physical Rehabilitation

**Continued Stay Review**

Authorization **DOES NOT** guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>UR Rep Name:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td></td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

*The facility has agreed to share the status of the authorization with the physician and client.*

**Timelines for clinical information to be faxed to Xerox:**

In order to avoid any gaps in coverage, the CSR MUST be received on the last covered day.

### CLIENT INFORMATION

Name: ___________________________  Medicaid ID#: __________

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. 
2. 
3. 
4. 
5. 
6.

*Please attach current multi-disciplinary team notes.*

Patient continues to receive three (3) hours of therapy per day, five (5) days per week.  Yes  No

Patient continues to receive two (2) therapy modalities per day?  Yes  No

Patient’s progress (PT, OT, ST, notes, new goals)

Treatment plan reviewed and/or revised every week?  Yes  No

Anticipated discharge date and needs:

---

Fax completed form to Xerox toll free @ 1-888-245-1928

Forms can be found online at [www.wyhealth.net](http://www.wyhealth.net)
# Skilled Nursing Extraordinary Care Admission Authorization

Authorization **DOES NOT** guarantee payment or client eligibility.

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>UR Rep Name:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Authorization #:</td>
<td></td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

**Timelines for clinical information to be faxed to Xerox:**

Skilled Nursing Facility Extraordinary Care: One (1) Working Day from the date of admission.

**Required Documentation: (M=Medical, P=Psych)**

1. PASRR (Level I) (M)  
2. PASRR (Level II) (P)  
3. LT101 less than 45 days old (M)  
4. MDS Assessment-ADL Sum of Ten (10) or more (M)  
5. History & Physical < 1 yr old (M/P)  
6. Drug History (M/P)  
7. Nursing Care Plan (M)  
8. Treatment Plan with medical and behavioral strategies (P)  
9. Stabilization Plan (P)  
10. Resources/agreements for inpatient stabilization if needed (P)  
11. List of primary care and psychiatric doctors (P)  
12. Progress Notes (M/P)  
13. Global Assessment of functioning (GAF) score < 40 (P)  
14. MD statement w/diagnosis and expected LOS (M/P)  
15. Itemized Costs – “Rate Request Form” (M/P)

Attending/Referring Physician (first and last name):

Physician Medicaid ID#:

Physician Phone #:

**CLIENT INFORMATION**

Name:  
Medicaid ID#:

Address:  
Phone #:

DOB:  
Age:  
SS#:  
Sex: Male Female

Ventilator dependent?: Yes  No

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1.  
2.  
3.  
4.  
5.  
6.  

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Wyoming Nursing Facility
Extraordinary Care
Rate Request Form

Patient Name: [Redacted]
Medicaid ID: [Redacted]
Facility: [Redacted]
Project Time Period: [Redacted]

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

**REQUESTED NEGOTIATED RATE:**

<table>
<thead>
<tr>
<th>Services under Fee Schedule:</th>
<th>Negotiated Rate per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Care</td>
<td>$435.00</td>
</tr>
</tbody>
</table>

**Additional Staffing:**

| RN | $27.28 |
| LPN| $18.76 |
| CNA| $12.22 |

Add Staffing Time (list number of 1:1 hours required per day that is above standard care)

<table>
<thead>
<tr>
<th>Equipment (list type and cost/day):</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Supplies (list items and cost/day):</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wound Care (list items):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound VAC Rental</td>
<td>$</td>
</tr>
<tr>
<td>Wound VAC supplies:</td>
<td>$</td>
</tr>
<tr>
<td>Dressing Kits¹</td>
<td>$</td>
</tr>
<tr>
<td>Cost for 15 kids=</td>
<td>$</td>
</tr>
<tr>
<td>Canisters²</td>
<td>$</td>
</tr>
<tr>
<td>Cost of 10 canisters=</td>
<td>$</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>$</td>
</tr>
<tr>
<td>Cost /day=</td>
<td>$</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>$</td>
</tr>
<tr>
<td>Cost/day=</td>
<td>$</td>
</tr>
</tbody>
</table>

Sub-total Negotiated Rate $ 

Current Nursing Facility Per Diem Rate $ 

Net Extraordinary Care Rate $ 

¹ Maximum coverage of 15 kits per month
² Maximum coverage of 10 canisters per month
Skilled Nursing Extraordinary Care
Continued Stay Review

Authorization **DOES NOT** guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>UR Rep Name:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td></td>
<td>Authorization #:</td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

**Timelines for clinical information to be faxed to Xerox:**
In order to avoid any gaps in coverage, the CSR MUST be received on the last covered day.

**Required Documentation:** (M=Medical, P=Psych)

1. MDS Assessment (M)
2. Nursing Care Plan (M)
3. MD Orders (M/P)
4. Itemized Costs—“Rate Request Form” (M/P)
5. Progress Notes (M/P)
6. Treatment Plan with medical and behavioral strategies
7. Current GAF Score

**CLIENT INFORMATION**

Name:  
Medicaid ID#:  
Ventilator dependent?: Yes  No

ICD-9 CM code(s) (provide ALL code numbers, as well as diagnosis names):

1. 4.
2. 5.
3. 6.

HCPCS code(s) (provide ALL code numbers, as well as diagnosis names):

1. 4.
2. 5.
3. 6.

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
Wyoming Nursing Facility
Extraordinary Care
Rate Request Form

Patient Name:  
Facility:  
Medicaid ID:  
Project Time Period:  

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

**REQUESTED NEGOTIATED RATE:**

<table>
<thead>
<tr>
<th>Services under Fee Schedule:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Care</td>
<td>Check box if applies</td>
</tr>
</tbody>
</table>

**Additional Staffing:**

<table>
<thead>
<tr>
<th>Staffing Time (list number of 1:1 hours required per day that is above standard care)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>$27.28</td>
</tr>
<tr>
<td>LPN</td>
<td>$18.76</td>
</tr>
<tr>
<td>CNA</td>
<td>$12.22</td>
</tr>
</tbody>
</table>

Additonal services required (Invoices must accompany request to be considered)

**Equipment (list type and cost/day):**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**Medical Supplies (list items and cost/day):**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**Wound Care (list items):**

<table>
<thead>
<tr>
<th>Wound VAC Rental</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost/day=</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wound VAC supplies:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost for 15 kids=</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canisters</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of 10 canisters=</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (specify)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost /day=</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (specify)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost/day=</td>
<td>$</td>
</tr>
</tbody>
</table>

Sub-total Negotiated Rate: $ 

Current Nursing Facility Per Diem Rate: $ 

Net Extraordinary Care Rate: $ 

---

1 Maximum coverage of 15 kits per month
2 Maximum coverage of 10 canisters per month
Retrospective Review
Admission Authorization

Authorization DOES NOT guarantee payment or client eligibility

<table>
<thead>
<tr>
<th>Date Requested:</th>
<th>For Xerox Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Date Received:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Current Approved:</td>
</tr>
<tr>
<td>Facility NPI#:</td>
<td>Approved TD:</td>
</tr>
<tr>
<td>Facility UR Rep:</td>
<td>Denied:</td>
</tr>
<tr>
<td>UR Rep Phone #:</td>
<td>Certified Through/LCD:</td>
</tr>
<tr>
<td>UR Rep Fax #:</td>
<td>Reviewed By:</td>
</tr>
<tr>
<td>Projected DC Date:</td>
<td></td>
</tr>
</tbody>
</table>

The facility has agreed to share the status of the authorization with the physician and client.

Timelines for clinical information to be submitted to Xerox:
Retrospective Review: Within 30 calendar days of receipt of notification of eligibility

Attending Physician (first and last name):
Physician Wyoming Medicaid ID:  Physician Phone #:
Physician Address:

Was admission court ordered? (circle one) Yes  No   If yes, please attach court ordered paperwork

Type of Review: (Include admit date for each level of care and/or procedure date)

Physical Rehab         Transplant         SNF Extraordinary Care         VNS
Weight Loss Surgery    PRTF               Acute Psych

Reason for Requesting Review:  (check applicable statement)

Client was made eligible for Medicaid benefits retrospectively. What date did you confirm eligibility and/or received client’s ID number (mm/dd/yyyy)**   
Facility received provider number retrospectively. What date did you received facility’s Wyoming Medicaid provider number? (mm/dd/yyyy)**

**You must include supporting documentation that shows the notification date and reason, along with the complete medical record.**

CLIENT INFORMATION

Name:  Medicaid ID#:
Address:  Phone #:
DOB:  Age:  SS#:  Sex:  Male  Female
Primary Diagnosis:        Diagnosis Description:

If records are too large to be faxed they may be mailed to:

Xerox Care and Quality Solutions, Inc
PO Box 49
Cheyenne, WY 82003

Fax completed form to Xerox toll free @ 1-888-245-1928
Forms can be found online at www.wyhealth.net
6 Referral Forms Appendix B
WYhealth...Get Plugged In!
Care Management Referral Form

Client/Patient Information:
Name: __________________________ DOB: __________ Medicaid #: __________
Address: ________________________ City: _______________ , WY Zip: __________
Phone Number(s): ________________________ (h) ________________________ (c)
Parent/Guardian: ________________________ Phone Number: ________________________
Primary language spoken: ☐ English ☐ Spanish ☐ ________________________
Primary Diagnosis: ________________________

Reason for Referral: (check all that apply)
☐ Education re: dx/treatment plan ☐ Medication/treatment compliance
☐ Links to community resources ☐ Assist coordination of care ☐ Weight management
☐ Mental health/psychosocial concerns ☐ Other: ________________________

Helpful documents to attach if available: current medications list, history & physical, psychosocial assessment, recent progress note

Facility/Provider Information:
Referring Provider: ________________________
☐ PCP ☐ Psychiatrist ☐ RN/LPN
☐ LCSW/LPC ☐ ________________________
Facility/Office: ________________________
Phone Number: ________________________
Address: ________________________
City, State: ________________________ Zip: __________
Fax Number: ________________________
Additional Providers for patient (if applicable):
PCP: ________________________
Mental Health: ________________________
Other: ________________________

Send form by fax to 888-245-1928
Questions call 888-545-1710
Visit our website www.WYhealth.net

WY Health...Get Plugged In staff use:
Date received: ________________ Opened: ________ Deferred: ________ Staff Initials: ________
Referral Date:

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Behavioral Health</th>
<th>Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Care Management</td>
<td>□ Care Management</td>
</tr>
<tr>
<td></td>
<td>□ Medication Review</td>
<td>□ Medication Review</td>
</tr>
<tr>
<td></td>
<td>□ Disability Determination</td>
<td>□ Disability Determination</td>
</tr>
<tr>
<td></td>
<td>□ Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>

### Referral Source Contact Information

Program Making Referral: __________________________
Phone #: __________________________ Email: __________________________
Waiver Contact (If applicable): __________________________
Waiver Type: __________________________
Phone #: __________________________ Email: __________________________
DFS Contact (If applicable): __________________________
Phone #: __________________________ Email: __________________________
Other Contact: __________________________
Phone #: __________________________ Email: __________________________

### Patient Information

Patient Name: __________________________ Medicaid ID: __________________________
Address: __________________________ City: __________________________
Phone #: __________________________
Guardian Name (If applicable): __________________________ Phone #: __________________________
Pertinent patient history or information: __________________________

Purpose for Referral: __________________________

### For Xerox Use Only

Referral #: __________________________ Date Received: __________________________
CM Assigned: __________________________ Date Assigned: __________________________
7 Utilization Management Criteria
Appendix C
Wyoming Nursing Facility Extraordinary Care Criteria

Extraordinary Care clients services are covered when the below criteria is met, the services are individualized, specific, and consistent with symptoms or confirmed diagnosis, and not in excess of the recipient’s needs.

**Medical conditions considered under extraordinary care criteria:**

Clients who have an MDS Activities of Daily Living Sum score of ten (10) or more and required special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

1. Ventilator Dependence allows for automatic qualification without additional criteria being met
2. Cerebral Palsy (ICD 9 343) must have additional criteria below met
3. Morbid Obesity (ICD 9 278.01) must have additional criteria below met
4. Multiple Sclerosis (ICD 9 340) must have additional criteria below met
5. Quadriplegia (ICD 9 344.00, 344.01, 344.02, 344.03, 344.04, or 344.09) must have additional criteria below met:
   
   Must have **one** of the following:
   - Ventilator dependence
   - Tracheostomy
   - Coma
   - Seizures
   - Disease process involving five (5) or more functional areas of visual, motor, sensory, cognitive, coordination and/or bowel and bladder (Multiple Sclerosis only)
   - Spastic Quadriplegia (Cerebral Palsy only)

   **AND**

   Must have **three** of the following:
   - Skin care could include Stage 3 or 4 ulcer/turning every two hours
   - Foley incontinence care could include urinary tract infections/diarrhea/constipation/bowel and bladder training
   - Tube feedings/aphasia could include dehydration/weight loss/aspiration pneumonia
   - Physical therapy could include wound care/range of motion exercises.
   - Special equipment used only by this resident that is clearly above and beyond what is covered in the per diem rate.

**Enhanced Psychiatric conditions considered under extraordinary care criteria:**

Adult clients presenting with a severe and persistent mental illness (SPMI) with long term psychiatric and behavioral health needs who exhibit challenging and difficult behaviors that is beyond traditional skilled nursing home care as recognized and prior authorized by the Department.
Specific Criteria (must meet all):

1. The client has a SPMI as defined by the following:
   a. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders
   b. Prior to admission (admission to hospital stabilization or nursing home), the Global Assessment of Functioning (GAF) score is 40 or lower.
2. The level of impairment is confirmed by a level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128)

Note: Refer to http://wyequalitycare.acs-inc.com/manuals for additional information on the PASRR screening process.

1. The person is currently in a psychiatric hospital; or has had one or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization.
2. The client exhibits chronic, unsafe behaviors that cannot be managed under traditional nursing facility care; including one of the following:
   a. Combative and assaulting behaviors (physical abuse toward staff, or self-abuse/self-injurious behaviors)
   b. Sexually inappropriate behaviors (touching or grabbing others, for example)
   c. Other challenging and difficult behaviors related to the individual's psychiatric illness

Continued Eligibility Criteria

Continued stay is applicable when the client either

1. Exhibits unsafe behavior according to #4, or
2. Exhibits the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidenced by exploratory visits without enhancements.

Discharge from Extraordinary Care Criteria

Discharge from Extraordinary Care Criteria is contingent upon:

1. The consistent absence of unsafe behaviors (as outlined in Specific Criteria) within consistently structured enhanced care
2. The anticipation that the individual will not exhibit the unsafe behaviors if moved from the enhanced services available in the nursing facility, as evidenced by exploratory visits without enhancements.

Note: These criteria must be closely observed and monitored during a continuous period of at least three months (quarterly).

Additional determining criteria for discharge include the following:

a. Monitoring of medication stability/consistency
b. Treatment compliance
c. Appropriate living arrangements upon discharge
d. Arrangement of aftercare for continued services
Any requests for a behavioral health extraordinary care client must include the following prior to any review by the Division of Healthcare Financing:

1. A treatment plan that specifies both medical and behavioral strategy
2. A stabilization plan to include both internal policies and plans for community based supports and if necessary transfer opportunities.
3. External resources, agreements, working partnerships for inpatient stabilization (if behavior escalates to a point where for their safety or those of the other patients or staff), with a written agreement to return client to resident location upon stabilization and recommendation plan in place.
4. List primary care and psychiatric doctors
5. Packet must include clinical justification and financial request as with any other extraordinary care client.

**Other conditions where special care or clinically complex care is required will be evaluated on a case by case basis by the Department. Criteria are subject to change.

Provider Documentation Required:

New Requests: Completed packet (following) and required documentation and cost review. Prior approval (PA) required for all extraordinary care clients.

Extraordinary Care Client packets can be faxed to Xerox at: 888-245-1928

Continued Stay Review: Completed Continued Stay form and required documentation. Prior approval (PA) required for all continued stay extraordinary care clients.

Annual Cost Review: For extraordinary care client rates will be done in conjunction with October 1 rate effective date reviews.

Continued Stay Reviews: Utilization review at 15 days, 30 days, 90 days and yearly thereafter. Or as needed if medical or psychiatric evaluation shows difference or change in services.

If client has a change in services needed, provider can submit new cost information for consideration or rate adjustment. Notify Myers & Stauffer of change for modification to reimbursement. 1-800-336-7721.

Please include all costs for residents under extraordinary care negotiated rate; as incremental revenue of negotiated rate is offset against applicable cost report.